NATIONAL ACCESS CANNABIS

Referral Form

Fax to (204) 615-8979
OR
Drop off at 379 Broadway – Unit 101 Winnipeg
(Access from Edmonton St)

Patient Information

Name: _____

PHIN: _____

REG. #: _____

Street Address: _____

Telephone #: _____

City/Province/Postal Code: _____

Date of Birth (MM/DD/YYYY): _____

Can a voice message be left at this number to schedule an appointment? Yes ◯ No ◯

Patient Diagnosis and Symptoms:

_____

_____

Current Treatments/Medications:

_____

_____

Other Relevant History:

_____

_____

Reminder Checklist

◯ (Required) Referral form complete

◯ (Supplementary) Additional Medical Documents supporting client diagnosis

◯ (Supplementary) Prescription and treatment history for anything not described on the Referral Form

A consultation appointment will be scheduled once ALL the requested information has been received and reviewed.

Referring Physician/Nurse Practitioner: _____ Manitoba Billing #: _____

Address: _____

Telephone: (_____) _____ - _____

Fax: (_____) _____ - _____

Signature: _____

Date (MM/DD/YYYY): _____ / _____ / _____

let's talk answers